Date: _____

Patient Name/DOB:

1._____
2._____
3._____
4._____

To Pediatric Associates Inc., of Brockton:

I, _____, give permission for the following people to seek medical evaluation and treatment for my child(ren) from Pediatric Associates of Brockton in my absence.

I understand this treatment may include any immunizations or treatments and the sharing of Protected Health Information that the provider at Pediatric Associates Inc., of Brockton finds medically necessary.

This Permission to treat my child(ren) will be in effect until withdrawn in writing.

Parent Signature: _____

Persons allowed to bring child in for treatment:	Relationship to child/phone #: